COUNTY OF LOS ANGELES
Public Health

SUSPECT CANDIDA AURIS REPORT FORM

Fax completed form and laboratory results to Morbidity Unit at (888) 397-3778

PATIENT INFORMATION

Patient Name- Last, First	Facility name (if not living at home):	Date of Birth	Age

Address- Number, Street, Apt #	City of Residence	State	ZIP Code

Patient's current gender identity?
☐ Male ☐ Female
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female ☐ Other: _____ ☐ Prefer not to state

Patient's sex at birth?
☐ Male ☐ Female ☐ Non-Binary or X
☐ Other: _____ ☐ Prefer not to answer

Patient's race or ethnicity? (check all that apply)
☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ Other: _____ ☐ Refused

LABORATORY INFORMATION

Accession Number	Specimen Collection Date	Result Date	Laboratory Name/Performing Facility

Specimen Source: ☐ Blood ☐ Nasal swab ☐ Rectal swab ☐ Respiratory ☐ Skin swab ☐ Urine
☐ Wound: ☐ open (non-sterile) ☐ surgical (sterile) ☐ Other: _____

Resulted Organism:
☐ *Candida auris (C. auris)* ☐ *C. famata* ☐ *C. intermedia* ☐ *C. sake*
☐ *C. catenulate* ☐ *C. guilliermondii* ☐ *C. lusitaniae* ☐ *Rhodotorula glutinis*
☐ *C. duobushaemulonii* ☐ *C. haemulonii* ☐ *C. parapsilosis* ☐ *Saccharomyces kluyveri*

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Testing Method: (check one only)
☐ API 20C ☐ bioMérieux VITEK MS MALDI-TOF ☐ MicroScan ☐ Other: _____
☐ API ID 32C ☐ Bruker Biotyper MALDI-TOF ☐ RapID Yeast Plus
☐ BD Phoenix ☐ GetMark ePlex BCID-FP Panel ☐ Vitek 2 YST

CLINICAL INFORMATION

Facility Name	Admit date	Currently admitted? ☐ Yes ☐ No	Discharge date

Infection status: ☐ Colonization ☐ Infection ☐ Unsure/Unknown

Was patient previously colonized prior to current admission? ☐ Yes ☐ No ☐ Unknown

Disposition: ☐ Discharged to facility name: _____ ☐ Discharged home ☐ Fatal - Date of Death: _____ ☐ Other: Specify. _____

EPIDEMIOLOGIC RISK FACTORS

Has the patient stayed overnight in a healthcare facility within the past 12 months? ☐ Yes ☐ No ☐ Unknown

If Yes, Healthcare facility location was: ☐ Outside of US ☐ Inside US OR ☐ Both

Specify dates of admission and state/country. _____

_____

History of carbapenemase-producing organism? ☐ Yes ☐ No ☐ Unknown If Yes, Date of collection. _____

If Yes, Specify test(s) performed (check all that apply): ☐ Carba NP ☐ eCIM ☐ mCIM ☐ Modified Hodge Test (MHT) ☐ PCR-based
☐ Other. _____

Epi-linked to another case? ☐ Yes ☐ No ☐ Unknown If Yes, Case Name & birthdate. _____

REMARKS

Submitter's name (print)	Date Completed	Telephone number ( )